Anthem

Colorado Health Plan Description Form
Anthem Blue Cross and Blue Shield
Centennial (PPO) Plan for the State of Colorado
Effective January 1, 2005 through June 30, 2005

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred provider plan
2. OUT-OF-NETWORK CARE COVERED?[1]	Yes, but patient pays more for out-of-network care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage.

	IN-NETWORK	OUT-OF-NETWORK
4. ANNUAL DEDUCTIBLE Individual Family	 $1,000 $2,000 for all family members	 $2,000 $4,000 for all family members
5. OUT-OF-POCKET ANNUAL MAXIMUM[2]	$2,500 (member paid coinsurance) + Deductible individual or $5,000 (member paid coinsurance) + Deductible family The in-network out-of-pocket maximum is not applied towards the out-of-network out-of-pocket maximum. Eligible charges for Other Mental Health Care and Alcohol and Substance Abuse are included in the out-of-pocket annual maximum.	$5,000 (member paid coinsurance) + Deductible individual or $10,000 (member paid coinsurance) + Deductible family The out-of-network out-of-pocket maximum is not applied towards the in-network out-of-pocket maximum. Eligible charges for Other Mental Health Care and Alcohol and Substance Abuse are included in the out-of-pocket annual maximum.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum	No lifetime maximum
7A. COVERED PROVIDERS	PPO Provider Network. See provider directory for complete list.	All providers licensed or certified to provide covered benefits.
7B. WITH RESPECT TO NETWORK PLANS, ARE ALL THE PROVIDERS LISTED IN 7A. ACCESSIBLE TO ME THROUGH MY PRIMARY CARE PHYSICIAN?	Yes	Not applicable
8. ROUTINE MEDICAL OFFICE VISITS	80% after deductible	60% after deductible
9. PREVENTIVE CARE a) Children's Services b) Adult's Services	 80% not subject to deductible (up to age 13) 80% after deductible	 60% not subject to deductible (up to age 13) 60% after deductible

	In-Network	Out-of-Network
10. MATERNITY		
a) Prenatal care	80% after deductible	60% after deductible
b) Delivery & inpatient well baby care	80% after deductible	60% after deductible
11. PRESCTRIPTION DRUGS **Level of coverage and restrictions on prescriptions**		
a) Inpatient care	80% after deductible	60% after deductible
b) Outpatient care	Tier 1 generic formulary $15, tier 2 brand formulary $40, tier 3 non-formulary $60, tier 4 self-administered injectable drugs 30%, per prescription up to a 34-day supply.	Not covered
c) Prescription Mail Service	Tier 1 generic formulary $30, tier 2 brand formulary $100, tier 3 non-formulary $150, tier 4 self-administered injectable drugs 30%, per prescription up to a 90-day supply. For the tier 4 self-administered injectable prescription drugs, the 34-day supply maximum coinsurance per prescription is $250 and $500 per 90-day supply. Includes coverage for smoking cessation prescription legend drugs when enrolled in an Anthem Blue Cross and Blue Shield approved smoking cessation counseling program, up to $250 per member per benefit period, $500 per lifetime. If a provider prescribes a drug for which an FDA-approved Class A generic substitute is available, the benefit will be limited to the cost of the generic substitute. All medically necessary "dispense as written" and "no substitution" prescriptions do not allow a generic substitution and require prior authorization from Anthem Blue Cross and Blue Shield. If a brand name drug is used when a generic equivalent is available, you pay the brand formulary copayment or nonformulary copayment plus the retail cost difference between the brand name drug and generic substitution. For drugs on our approved list, contact Customer Service at 1-800-843-5621 or 303-831-2384. Prescription drugs will be covered only when received from a participating pharmacy.	Not covered

	IN-NETWORK	OUT-OF-NETWORK
12. INPATIENT HOSPITAL	80% after deductible	60% after deductible
13. OUTPATIENT/AMBULATORY SURGERY	80% after deductible	60% after deductible
14. LABORATORY AND X-RAY	80% after deductible	60% after deductible
15. EMERGENCY CARE[3]	80% after deductible	60% after deductible
16. AMBULANCE	80% after deductible (limited to $350 per trip for ground ambulance and $2,500 per trip for air ambulance)	60% after deductible (limited to $350 per trip for ground ambulance and $2,500 per trip for air ambulance)
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	80% after deductible	60% after deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS[4] **CARE**	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE		
a) Inpatient care	80% after deductible (limited to 45 full or 90 partial days per member per benefit period combined with out-of-network)	60% after deductible (limited to 45 full or 90 partial days per member per benefit period combined with in-network)
b) Outpatient care	80% after deductible (limited to 30 visits per member per benefit period combined with out-of-network and line 20 outpatient alcohol and substance abuse, with no less than $1,000 in benefits for mental health care)	60% after deductible (limited to 30 visits per member per benefit period combined with in-network and line 20 outpatient alcohol and substance abuse, with no less than $1,000 in benefits for mental health care)
20. ALCOHOL & SUBSTANCE ABUSE		
a) Inpatient care	80% after deductible limited to medically necessary care	60% after deductible limited to medically necessary care
b) Outpatient care	80% after deductible (limited to 30 visits per member per benefit period combined with out-of-network and line 19 outpatient mental health care, with no less than $500 in benefits for alcohol abuse and no less than $250 in benefits for substance abuse)	60% after deductible (limited to 30 visits per member per benefit period combined with in-network and line 19 outpatient mental health care, with no less than $500 in benefits for alcohol abuse and no less than $250 in benefits for substance abuse)
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY	80% after deductible (limited to 20 visits each for physical, occupational, and speech therapy combined with out-of-network benefits)	60% after deductible (limited to 20 visits each for physical, occupational, and speech therapy combined with in-network benefits)
22. DURABLE MEDICAL EQUIPMENT	80% after deductible	60% after deductible
23. OXYGEN	80% after deductible	60% after deductible
24. ORGAN TRANSPLANTS	80% after deductible	60% after deductible
25. HOME HEALTH CARE	80% after deductible (up to 60 visits per benefit period combined with out-of-network benefits)	60% after deductible (up to 60 visits per benefit period combined with in-network benefits)
26. HOSPICE CARE		
a) Inpatient	80% after deductible	60% after deductible
b) Outpatient	80% after deductible	60% after deductible

	IN-NETWORK	OUT-OF-NETWORK
27. SKILLED NURSING FACILITY CARE	Not covered	Not covered
28. DENTAL CARE	No dental benefits are available under this medical plan. However, the State of Colorado offers a separate dental plan for eligible employees and dependents. See enrollment materials.	
29. VISION CARE	Vision benefits included in this plan can be found on the separate Anthem Vision Summary Description.	
30. CHIROPRACTIC CARE	80% after deductible (limited to a maximum payment of $750 per benefit period combined with out-of-network)	60% after deductible (limited to a maximum payment of $750 per benefit period combined with in-network)
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	BlueCares for You disease management programs that include management for CAD, CHF, ESRD, maternity, asthma, diabetes, and a 24-hour nurse healthline. Hearing aids, exam and fitting not subject to deductible or coinsurance (limited to maximum payment of $500 every three years combined with out-of-network) Infertility treatment 80%, subject to deductible (limited to a maximum payment of $2,500 per benefit period combined with out-of-network) When a member desires another professional opinion, they may obtain a second surgical opinion subject to plan provisions. A benefit period begins on the subscriber's effective date, and expires on the following June 30.	BlueCares for You disease management programs that include management for CAD, CHF, ESRD, maternity, asthma, diabetes, and a 24-hour nurse healthline. Hearing aids, exam and fitting not subject to deductible or coinsurance (limited to maximum payment of $500 every three years combined with in-network) Infertility treatment 60%, subject to deductible (limited to a maximum payment of $2,500 per benefit period combined with in-network) When a member desires another professional opinion, they may obtain a second surgical opinion subject to plan provisions. A benefit period begins on the subscriber's effective date, and expires on the following June 30.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[5]	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable. Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy, a list of exclusions is available immediately upon request from your carrier or plan sponsor (e.g. employer). Review them to see if a service or treatment you may need is excluded from the policy.

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PART D: USING THE PLAN

	USING THE PLAN	
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield
39. What is the main customer service number?	303-831-2384 or 1-800-843-5621	
40. Whom do I write/call if I have a complaint or want to file a grievance?[6]	Anthem BCBS Complaints and Appeals 700 Broadway Denver, CO 80273 303-831-2384 or 1-800-843-5621	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850 Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form # 96744 Large group	

PART E: COST

43. What is the cost of this plan?	**Employee Portion**	**State Contribution**	**Full Premium**
Employee Only	$44.18	$178.06	$222.24
Employee + 1 Dependent	$137.70	$303.50	$443.20
Employee + 2/More Dependents	$196.36	$420.02	$616.38

PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION, AND PROFIT

Any person interested in applying for coverage, or who is covered by or who purchased coverage under this plan, may request answers to the questions listed below. The request may be made orally or in writing to the insurance company and shall be answered within five (5) working days of the receipt of the request.

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?
- What percentage of total Colorado premiums are spent on health-care expenses as distinct from administration and profit?

Endnotes:

1. "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

2. "Out of Pocket Maximum" The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.

3. "Emergency Care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and

medicine and acting reasonably would have believed that an emergency medical condition or life-or-limb threatening emergency existed

4. "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

5. Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

6. Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

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ANTHEM VISION SUMMARY OF BENEFITS

This Summary Plan Description outlines the vision benefits available to you through the Anthem Vision Plan. This is a summary of your vision benefit. Please review your benefit certificate for plan details. For eligibility definitions please contact your group administrator.

Anthem Vision's Provider Network: **Anthem Vision** contracts with many providers which includes independent optometrists and ophthalmologists as well as retail locations. Anthem members have access to approximately 10,000 conveniently located providers nationwide. Members may call Anthem Vision toll-free (800) 231-2583 or visit www.anthem.com any time for provider locations. Schedule an appointment with your Anthem provider; identify yourself as an Anthem vision member for fast, paperless determination and confirmation of benefits.

Network Provider: Maximum benefits are achieved when members access their benefits from an ***Anthem*** Participating Vision Provider. Copayment(s) may apply to in-network benefits.

Non-Network Vision Provider Reimbursements: Members may go to a non-participating (non-network) vision provider and pay the provider directly for their examination. Members may then submit an original itemized invoice along with the Member's I.D. number to ***Anthem Vision*** for reimbursement according to the Non-Par Reimbursement schedule identified in this Summary of Benefits.

Materials: Anthem *Providers* agree to Preferred Pricing that is significantly below retail. Members are able to achieve substantial savings on frames, lenses or contact lenses, lens treatments, specialized lenses and various sundry items. Members may save approximately 20% to 40% or more off retail when they visit an ***Anthem*** Provider.

Copayment(s): Copayment amounts are applicable to Network Vision Provider examinations.

Anthem Vision Benefits	Member Benefit from Network Provider	Non-Par Reimbursement**
Vision Examination: Each member is entitled to a comprehensive vision examination by an Anthem Vision Provider. This is a vision examination only and does not cover a separate contact lens professional fitting fee. ***Availability*** **: Once every 12 months***	**Copayment $20**	**Up to reimbursement of $35**
Materials: Prescription lenses and frames	**Available at Anthem Vision Preferred Prices**	**Not covered**
Contact lenses:	**Available at Anthem Vision Preferred Prices**	**Not covered**

**** Benefit are available from the last date of service.***

Limitations and Exclusions:

This is a primary vision care benefit and is intended to cover only eye examination only. Materials and any items not covered may be purchased at Preferred Pricing from an Anthem Vision Provider. In addition, the examination is only payable while the Group and individual Member coverage is in force.

- Orthoptics or vision training and any supplemental testing.
- Medical or surgical treatment of the eyes.
- An eye exam or corrective eyewear required by an employer as a condition of employment.
- Any injury or illness covered under Workers' Compensation or similar law, or which is work related.
- Sub-normal vision aids.
- Experimental or non-conventional treatments or devices.
- Safety eyewear.